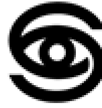

ALBUQUERQUE AMBULATORY
Eye Surgery Center

CONSENT FOR SURGERY OR PROCEDURE

Patient Name____

Surgeon/s____

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Consent to surgery or procedure: I acknowledge that I have authorized and directed my surgeon (or his/her assistants of choice) to perform the following operation or procedure on me, and to administer any necessary medications chosen, to provide any additional services that he/she deems necessary or advisable on the basis of findings during the course of said operation, including but not limited to services involving pathology, and the disposal of any severed tissue or organ.

Risks/Alternatives: My surgeon (or his/her assistant of choice) has explained the nature of the operation or procedure, the expected benefits or effect, any medically acceptable alternatives, and the associated risks and the risks of NOT performing the procedure. I certify that based upon the information provided by my surgeon, I have a general understanding of the operation or procedure to be performed on me and that no warranty or guarantee has been made as to the result.

Consent to transfer: I understand that the surgery or procedure performed on me at AAESC will be done on an outpatient basis and the AAESC does not provide 24-hour patient care. If my attending practitioner shall find it necessary or advisable to transfer me to a hospital, I consent and authorize the employees of AAESC to arrange for and affect the transfer.

Financial arrangements and authorization for Insurance and Medicare payments: I authorize payment of benefits to AAESC, to the surgeon (or his/her assistants of choice) rendering service, the anesthesia provider rendering service, or the pathologist rendering service. I understand I am responsible to AAESC for charges not covered by this assignment, and I agree to pay all AAESC charges not paid in full by a third-party payer. All delinquent accounts bear interest at the legal rate.

It is understood and agreed that reasonable attorney fees and/or open account interest charges assessed are payable by me.

I agree to assist in the processing of claims for benefits.

I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

Release of information: I authorize the release to the Social Security Administration and Healthcare Financing Administration any information needed for this or a related Medicare claim.

I authorize the release of medical or other information about me, which may be necessary for the completion of insurance claims, for the review of services, or for receipt of benefits to third-party payers.

Personal valuables: AAESC is not responsible for personal property.

Observers: I hereby authorize observers to be present during my surgery or procedure for the purposes of their medical training or education. The observer has no role or responsibility in performing the procedure on me.

Photographing or videotaping: I consent to the photographing or videotaping of the surgery or procedure to be performed for medical or educational purposes, provided my identity is not revealed by the pictures or by descriptive texts accompanying them. The photographs or videos will become the property of AAESC.

Certification: I acknowledge that I have read (or have had this consent read to me) and fully understand the explanations given and that all blanks requiring completion were filled in before I affixed my signature. A photocopy of this authorization shall be considered as effective and valid as the original.

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Patient Signature (or authorized representative and relationship to patient)

Witness___________________________Date__________Time __________